Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

BEVERLEE JOHNSON
7817 W PARK LN
MANSFIELD TX 76063

Respondent Name:
TWIN CITY FIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number:
M4-11-4697-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "2nd-L knee surgery – W/C P/T (I paid!!!) Post-op pain; H/p; diabetic; workcomp"

Amount in Dispute: $240.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: It appears the only bill ($136.00) attached is for co-pays. We can only reimburse full payment to the provider. Claimant will need to seek reimbursement for co-pays from BC/BS. We do not see any additional billing for the remaining disputed DOS. The requestor did not provide evidence of payment and therefore we cannot review for processing. We also will not pay any additional monies past 6/17/11 as the claimant has entered into a 3rd party settlement. See attached pln11. Also, see attached letter stating the knew surgery is not covered/compensable. Claimant went though health ins for this.

Response Submitted by: The Hartford, 300 S. State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2001 through July 25, 2011	Out-of-Pocket Expenses	$240.00	0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - EOBs not submitted by either party.

Issues

1. Did the requestor submit the receipts for out-of-pocket medical expenses to the Carrier in accordance with 28 Texas Administrative Code §133.270?
2. Did the requestor submit convincing evidence that the out-of-pocket medical expenses were submitted to the Carrier in accordance with 28 Texas Administrative Code §133.307?
3. Is the requestor entitled to reimbursement?

Findings

Pursuant to 28 Texas Administrative Code "§133.270 (a) An injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in: (1) Insurance Code §1305.451, or (2) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee). (b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider."

According to 28 Texas Administrative Code §133.307(c)(3) "An employee who has paid for health care may request medical fee dispute resolution of a refund or reimbursement request that has been denied. The employee's dispute request shall be sent to the MDR Section by mail service, personal delivery or facsimile and shall include: (A) the form DWC-60 table listing the specific disputed health care in the form and manner prescribed by the Division; (B) an explanation of the disputed amount that includes a description of the health care, why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount; (C) Proof of employee payment (including copies of receipts, provider billing statements, or similar documents); (D) a copy of the carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received, convincing evidence of the employee's attempt to obtain reimbursement or refund from the carrier or health care provider."

Review of the documentation submitted by the Requestor does not include convincing evidence of the employee's attempt to obtain reimbursement from the carrier. Therefore, in accordance with 28 Texas Administrative Code §133.307(e)(3)(I) the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	September 14, 2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).